



Rural Health Clinic (RHC) and Federally Qualified Health Clinic (FQHC) Coverage and Billing Updates – JA6445

Note: JA6445 was revised to add a reference to MM7038, which is available at <http://www.cms.gov/MLN MattersArticles/downloads/MM7038.pdf>, that alerts FQHCs to the new increased coverage of preventive services in the FQHC setting enacted as a part of the Affordable Care Act.

Related CR Release Date: April 24, 2009 **Revised**

Date Job Aid Revised: December 22, 2010

Effective Date: October 1, 2009

Implementation Date: October 5, 2009

Key Words	MM6445, CR6445, R1719CP, RHC, FQHC, Billing
Contractors Affected	<ul style="list-style-type: none"> • Fiscal Intermediaries (FIs) • Part A/B Medicare Administrative Contractors (A/B MACs)
Provider Types Affected	All RHCs and FQHCs submitting claims and cost reports to Medicare FIs and A/B MACs for services and supplies provided to Medicare beneficiaries.



Change Request (CR) 6445 updates billing and cost reporting for the following preventive benefits and vaccines provided by RHCs and FQHCs with various effective dates:

- Initial preventive physician examination (IPPE);
- Ultrasound screening for abdominal aortic aneurysm (AAA);
- Individual services for diabetes self-management training (DSMT) services;
- Individual services for medical nutrition therapy services (MNT); and
- Certain vaccines.

Provider Needs to Know...	<ul style="list-style-type: none"> • Payment for professional services that meet all of the program requirements is made under the all-inclusive rate. • The IPPE and the ultrasound screening for AAA are once in a lifetime benefits.
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- Therefore, Healthcare Common Procedure Coding System (HCPCS) coding is required to adhere to the statutory limit for the following reasons:
 - To allow for the deductible to be waived when computing payment to RHCs for dates of service (DOS) on or after the effective dates (**Note:** Deductible is never applied for FQHC services); and
 - In rare circumstances, depending on the clinical appropriateness of a separate visit, to allow RHCs and FQHCs to receive separate payment for an encounter in addition to the payment for IPPE or AAA encounter when they are performed on the same day.

Policy Clarifications for IPPEs

- Effective for DOS on or after January 1, 2009, RHCs and FQHCs may bill for the professional portion of an IPPE in addition to a daily encounter by using:
 - Type of bills (TOBs) 71X and 73X, respectively;
 - The appropriate site of service revenue code in the 052X revenue code series; and
 - HCPCS G0402.
- For RHCs, the Part B deductible for the IPPE is waived for DOS on or after January 1, 2009.
- FQHC services are already exempt from the Part B deductible. **Coinsurance is applicable.**

Note: The technical component of an electrocardiogram (EKG) performed at a clinic/center is not a Medicare-covered RHC/FQHC service and is not billed by the independent RHC or FQHC. Rather, it is billed to Medicare Carriers or Part B MACs on professional claims (Form CMS 1500 or 837P) under the practitioner's national provider identifier (NPI), following instructions for submitting practitioner claims. The technical component of the EKG performed at a provider-based clinic/center is not a Medicare-covered RHC/FQHC service and is not billed by the provider-based RHC or FQHC. Instead, it is billed on the applicable TOB and submitted to the FI or Part A MAC using the base provider's NPI, following instructions for submitting claims to the FI/PART A MAC from the base provider.

Policy Clarifications for Ultrasound Screening for AAA

- Effective for DOS on or after January 1, 2007, RHCs and FQHCs need not apply the Part B deductible when billing for ultrasound screening for AAA using the HCPCS code G0389.
 - The professional portion of the service is billed to the FI or A MAC using:
 - TOBs 71X (RHCs) and 73X (FQHCs);
 - The appropriate site of service revenue code in the 052X revenue code series; and
 - HCPCS G0389.
- FQHC services are already exempt from the Part B deductible. **Coinsurance is applicable.**

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- If the AAA screening is provided in an independent RHC or freestanding FQHC, the technical component of the service can be billed by the practitioner to the carrier or Part B MAC under the practitioner's NPI following instructions for submitting practitioner claims.
 - If the screening is provided in a provider-based RHC or FQHC, the technical component of the service can be billed by the base provider to the FI or Part A MAC under the base provider's NPI, following instructions for submitting claims to the FI/Part A MAC from the base provider.

Policy Clarifications for DSMT and MNT Services

FQHCs

- Effective for DOS on or after January 1, 2006, FQHCs may not bill for group services for DSMT or MNT services as a separate qualifying encounter. Group services do not meet the criteria for a separate qualifying encounter. Therefore, they cannot be billed as an encounter.
- DSMT and MNT services may be provided in a group setting, but do not meet the criteria for a separate qualifying encounter. Therefore, these services cannot be billed as an encounter. Rather, the cost of group sessions is included in the calculation of the all-inclusive FQHC visit rate.
- Claims for DSMT group services with HCPCS code G0109 and MNT group services with HCPCS codes 97804 or G0271 will be denied using group code CO (Contractual Obligation) and claim adjustment reason code B5 ("Program coverage guidelines were not met or exceeded.").
- FQHCs may bill for DSMT and MNT services when they are provided in a one-on-one, face-to-face encounter, and they are billed using the appropriate HCPCS and site of service revenue codes.
 - To receive payment for DSMT services, the DSMT services must be billed on TOB 73X with HCPCS code G0108 and the appropriate site of service revenue code in the 052X revenue code series. This payment can be in addition to payment for any other qualifying visit on the same date of service that the beneficiary received qualifying DSMT services as long as the claim for DSMT services contains the appropriate coding specified above.
 - To receive payment for MNT services, the MNT services must be billed on TOB 73X and with the appropriate site of service revenue code in the 052X revenue code series and the appropriate HCPCS code (97802, 97803, or G0270). This payment can be in addition to payment for any other qualifying visit on the same DOS as the beneficiary received qualifying MNT services as long as the claim for MNT services contains the appropriate coding specified above.

RHCs

- Separate payment to RHCs for these practitioners and services continues to be precluded.
 - However, RHCs are permitted to become certified providers of DSMT services and report the cost of such services on their cost report for inclusion in the computation of
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their all-inclusive payment rates. Note that the provision of these services by registered dietitians or nutritional professionals might be considered incident to services in the RHC setting, provided all applicable conditions are met.

- However, they do not constitute an RHC visit, in and of themselves. All line items billed on TOB 71x with HCPCS code G0108 or G0109 will be denied.

Policy Clarifications for Vaccines

- RHCs and FOHCs do not report charges for influenza virus or pneumococcal pneumonia vaccines on the 71x/73x claims. Costs for the influenza virus or pneumococcal pneumonia vaccines are included in the cost report and no line items are billed. CR6445 clarifies that neither co-insurance nor deductible apply to either of these vaccines.
- Hepatitis vaccine is included in the encounter rate. No line items specifically for this service are billed on RHC or FOHC claims. The cost of the vaccine and its administration can be included in the line item for the otherwise qualifying encounter. Both co-insurance and deductible apply to this benefit. An encounter cannot be billed if vaccine administration is the only service the RHC or FOHC provides.

Background

- For RHCs and FOHCs, professional components of preventive services are part of the overall encounter. They have always been billed on lines with the appropriate site of service revenue code in the 052x series TOBs 71x and 73x.
- As of April 1, 2005, RHCs and FOHCs were only required to report HCPCS codes for a few services.
- The number of RHC and FOHC services requiring HCPCS coding is increasing because:
 - The number of new benefits subject to frequency limits is increasing;
 - For certain preventive benefits, no deductible is applicable on RHC services (All FOHC services are already exempt from application of the deductible.); and
 - The number of circumstances when a provider is eligible to receive payments in addition to the all-inclusive daily encounter rate has increased.

Operational Impact

Contractors will not search for claims but should adjust claims brought to their attention.

Reference Materials

The related MLN Matters® article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6445.pdf> on the CMS website.

The official instruction (CR6445) issued regarding this change may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1719CP.pdf> on the CMS website.
